PREFERRED ACCESS (PPO) PLAN

	COST SHARING	
	IN-NETWORK	OUT-OF-NETWORK
Deductible Maximum out of Pocket for Covered Expenses After Deductible Coinsurance Lifetime Maximum Benefit	Single $750, $1500 Family $1500, $3000 Single $3000, $5000 Family $6000, $10,000 As indicated $2 million for in-network and out-of-network benefits	Single $750, $1500 Family $1500, $3000 Single $3000, $5000 Family $6000, $10,000 As indicated $2 million for in-network and out-of-network benefits
In-Hospital Care - Authorized Semi Private Room and Misc. Services, Intensive/Cardiac/Neonatal	20% Co-insurance Amount*	40% Co-insurance Amount*
Ambulatory/Hospital Outpatient Surgery	20% Co-insurance Amount*	40% Co-insurance Amount*
Transplant (Kidney, Cornea, Bone Marrow, Heart, Liver, Lung, Heart/Lung, Pancreas, Small Bowel)	20% Co-insurance Amount*	40% Co-insurance Amount*
Out-Patient Services - Provider Office Visit, Diabetes Education and Therapy, Radiation, Chemotherapy, and Dialysis, diagnostic testing Diagnostic Testing Allergy testing, Allergy Serum and Injections	$20 Co-payment (includes all services provided during the office visit) 20% Coinsurance (for services not provided during the office visit) Not Covered	$20 Co-payment (includes all services provided during the office visit) 20% Coinsurance* Not Covered
Maternity Care - Prenatal, Labor, Delivery and Postpartum (Pregnancy of Dependents Covered)	20% Co-insurance Amount*	40% Co-insurance Amount*
Emergency Services - Hospital Emergency Room (Coinsurance Waived if Admitted)	20% Co-insurance Amount*	20% Co-insurance Amount*
Ground Ambulance Only	20% Coinsurance Amount*	20% Coinsurance Amount*
Preventive Services: Immunizations Well Child Care - Age and Periodicity Limits May Apply Well Adult Care - Age and Periodicity Limits May Apply	 20% Co-insurance Amount* $20 Co-payment $20 Co-payment	 20% Co-insurance Amount* $20 Co-payment $20 Co-payment
Mental Health: Inpatient Outpatient	 50% Co-insurance amount maximum 21 days per plan year and 1 admission per 6 months* (Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis) 50% Co-insurance Amount*, 20 visits per plan year	 50% Co-insurance amount maximum 21 days per plan year and 1 admission per 6 months* (Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis) 50% Co-insurance Amount*, 20 visits per plan year
Autism - $500 Monthly Benefit for Children Ages 2 through 21 Years of Age for Therapeutic, Respite and Rehabilitative Care	Coinsurance Applicable to Service Provided*	Coinsurance Applicable to Service Provided*
Substance Abuse: Inpatient Outpatient	 50% Co-insurance amount maximum 21 days per plan year and 1 admission per 6 months* (Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis) 50% Co-insurance Amount*, 20 visits per plan year	 50% Co-insurance amount maximum 21 days per plan year and 1 admission per 6 months* (Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis) 50% Co-insurance Amount*, 20 visits per plan year
Prescription Drugs, including Oral Contraceptives	Separate deductible for prescription drugs of $250/$500 (Single) $500/$1000 (Family) applies to both in-network and out-of-network benefits. 20% co-insurance amount	Separate deductible for prescription drugs of $250/$500 (Single) $500/$1000 (Family) applies to both in-network and out-of-network benefits. 40% co-insurance amount

*Deductible Applies

PREFERRED ACCESS (PPO) PLAN

BENEFIT	COST SHARING	
	IN-NETWORK	OUT-OF-NETWORK
Physical Therapy	20% Co-insurance amount*	40% Co-insurance amount*
Cardiac Rehabilitation Therapy	20% Co-insurance amount*	40% Co-insurance amount*
Occupational Therapy	Not Covered	Not Covered
Speech Therapy	Not Covered	Not Covered
Home Health Care	20% Co-insurance amount*	40% Co-insurance amount*
Skilled Nursing Facility	Not covered	Not covered
DME/Prosthetics/Hearing Aids	20% Co-insurance amount*	40% Co-insurance amount*
Hospice	20% Co-insurance amount*	40% Co-insurance amount*

*Deductible Applies